GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 22, 2024

Roxanne Goldammer
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AS370405093
Investigation #: 2024A1029028
Beacon Home At Mt Pleasant

Dear Roxanne Goldammer:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS370405093
Investigation #:	2024A1029028
Complaint Receipt Date:	01/31/2024
Investigation Initiation Date:	01/31/2024
Report Due Date:	03/31/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St., Suite 110, Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldammer
Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home At Mt Pleasant
Facility Address:	4659 S Leaton Rd, Mt Pleasant, MI 48858
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/16/2020
License Status:	REGULAR
Effective Date:	05/16/2023
Expiration Date:	05/15/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Robb Lynch did not request a new prescription for Resident A's Keppra medication as requested by the pharmacy on January 15, 2024. As a result, Resident A was not administered his Keppra medication as prescribed and missed doses between January 27-January 30, 2024. Resident A had a seizure on January 30, 2024 and he was transported to the emergency room so he could receive the Keppra medication.	Yes

III. METHODOLOGY

01/31/2024	Special Investigation Intake 2024A1029028
01/31/2024	Special Investigation Initiated – Letter to Katie Hohner ORR
01/31/2024	APS Referral made to Centralized Intake
02/02/2024	Contact - Document Sent - Email to Marlo Derry and Roxanne Goldammer
02/09/2024	Inspection completed on-site - Face to Face with Robb Lynch, Angie Himebaugh, and Resident A at Beacon Home at Mt. Pleasant
02/09/2024	Contact – document sent – email to ORR Katie Hohner
02/14/2024	Contact - Telephone call made to licensee designee Roxanne Goldammer
02/20/2024	Contact - Telephone call made to Kendra Pannill
02/22/2024	Exit conference with licensee designee Roxanne Goldammer, left message and sent email.

ALLEGATION:

Direct care staff member Robb Lynch did not request a new prescription for Resident A's Keppra medication as requested by the pharmacy on January 15, 2024. As a result, Resident A was not administered his Keppra medication as prescribed and missed doses between January 27-January 30, 2024. Resident A

had a seizure on January 30, 2024 and he was transported to the emergency room so he could receive the Keppra medication.

INVESTIGATION:

On January 31, 2024, a complaint was received via the Bureau of Community and Health Systems online complaint system with allegations direct care staff member Robert Lynch ordered Keppra for Resident A on January 15, 2024 however the pharmacist informed Mr. Lynch Resident A required a new refill prescription before the medication could be sent, but Mr. Lynch did not follow-up leading to Resident A not receiving the seizure medication, Keppra. According to the allegation, due to Mr. Lynch's failure to follow up, Resident A missed doses of Keppra on January 27 and 28, 2024 causing Resident A to have a seizure on January 29, 2024. Resident A was taken to the Emergency Room to receive this dose of Keppra. Office of Recipient Rights (ORR) advisor, Katie Hohner is also investigating these concerns.

On February 9, 2024, I completed an unannounced on-site investigation at Beacon Home at Mt. Pleasant and interviewed direct care staff member Robb Lynch. Mr. Lynch showed me the January 2024 medication administration record (MAR) for Resident A. Mr. Lynch stated the prescriptions are sent right to Gull Pointe Pharmacy in Kalamazoo for all residents. Mr. Lynch stated Gull Pointe Pharmacy will deliver the medications to the home. Mr. Lynch stated he completes a medication count each Monday and on January 15, 2024, he noticed he needed to order Resident A's Keppra medication so he sent an email to the pharmacy. Mr. Lynch stated on January 15 Resident A's Keppra was reordered and at that time there were 12 tablets for AM and 12 tablets for the PM dose. Mr. Lynch stated the pharmacist Chris Rousch sent him an email back letting him know they needed a new prescription on January 15, 2024 at 1:05 PM, but Mr. Lynch stated he missed the email and did not follow up. I was able to review the email Mr. Lynch missed and it was also sent to Ms. Pannill, Beacon Specialized Living RN Chasidy Campbell, and licensee designee, Roxanne Goldammer. Mr. Lynch stated he was on vacation starting January 20, 2024 and he should have reviewed the email before he left. Mr. Lynch stated he also believed the prescription was good for a year so he did not think initially Resident A would need a new prescription. Mr. Lynch admitted it was his mistake and stated because he did not see the email, the prescription did not go in, and Resident A's Keppra medication ran out which could have led to Resident A's seizure on January 30, 2023. Mr. Lynch stated he did not know what the codes on the MAR meant when it said "AL*6" and "*17" but knew those were days Resident A was not administered the medication.

I reviewed Resident A's January 2024 MAR which showed the following documentation for Keppra:

January 27 AM – JA
*January 27 8 PM- AN*17* ***Missed dose.***
January 28 8 AM – AM
*January 28 8 PM – AL*6* ***Missed dose.***

*January 29 8 AM – JA*6 JA* ***Missed dose.***
*January 29 8 PM AN*17* ***Missed dose.***
January 30 8 AM – nothing documented – Resident A had the seizure and went to the hospital on January 30, 2024. ***Missed dose.***
January 30 8 PM – AL

On February 9, 2024, I interviewed direct care staff member Angie Himebaugh at Beacon Home at Mt. Pleasant. Ms. Keppra stated she was preparing to administer Resident A's medication on January 27, 2024 but she did not find any Keppra for him so she called Ms. Pannill who was on call. Ms. Himebaugh stated the medications are typically sent to the facility from Gull Pointe Pharmacy and she has never had an issue with a medication not being available. Ms. Himebaugh stated Mr. Lynch did not send a new prescription for the medication because he thought it was good for one year and the pharmacy did not send Resident A's Keppra. Ms. Himebaugh stated she called Ms. Pannill on Saturday January 27, 2024 at 7:11 PM to inform her because she was able to administer the AM dose to Resident A but there was no medication available for the evening dose. Ms. Himebaugh stated Ms. Pannill called her back at 7:35 PM and she informed her there were no more evening tablets. Ms. Himebaugh stated Resident A was administered the 8 AM dose of Keppra on Sunday, January 28, 2024 but missed the PM dose because the medication was not available. Ms. Himebaugh stated Resident A has only had one other seizure since he has resided at Beacon Home at Mt. Pleasant.

I was able to observe Resident A during my on-site but due to his autism diagnosis, he could not complete an interview regarding these allegations.

During the on-site investigation, I reviewed Resident A's resident record. According to a visit summary from October 24, 2023 written by DNP Paul Drenth, Resident A is diagnosed with seizure disorder and sees a neurologist through Spectrum Health and he is prescribed Keppra 500 MG tablet 2 times per day since September 5, 2023.

I reviewed Resident A's *Discharge Summary from MyMichigan Health* which confirmed Resident A was seen by William Sturdavant on January 30, 2024 with a diagnosis of Breakthrough Seizure. Under the section titled Instructions, "*Do not take more than 500 MG twice daily of Keppra. The additional prescription is meant to bridge until you are able to get your normal prescription."*

I was able to confirm the Keppra 500 MG was currently available to be administered to Resident A at Beacon Home at Mt. Pleasant. I also reviewed the current order which was dated January 29, 2024 for Keppra which included a note that a refill would be due on April 29, 2024.

On February 14, 2024, I interviewed licensee designee Roxanne Goldammer. Ms. Goldammer stated there was an email from Gull Pointe Pharmacy informing Mr. Lynch to notify the doctor for a new prescription and send it to pharmacy but this did not happen and as a result the medication was not delivered. Ms. Goldammer stated when

she met with Mr. Lynch about the concerns he said he was going to step down as the assistant home manager and owned up to his mistake. Ms. Goldammer stated she does not know if there is an exact policy regarding following up on these concerns. Ms. Goldammer stated at the time Resident A ran out of medications, Ms. Pannill was just returning to work. Ms. Goldammer stated was over the weekend he was missing the medications Resident A did receive one dosage per day instead of two.

On February 20, 2024, I interviewed direct care staff member whose current role is home manager, Kendra Pannill. Ms. Pannill stated on January 15, 2024 Mr. Lynch completed a medication count and reported to Gull Pointe Pharmacy he needed medications for Keppra for Resident A however he did not see the return email stating he needed a new prescription. Ms. Pannill stated Mr. Lynch thought the prescription was good for a year and did not understand he needed to get a new one. Ms. Pannill stated when she was informed on January 27, 2024 that Resident A did not have any more Keppra for his evening dosage she realized he would not have one for the 8 PM dosage. Ms. Pannill stated there was one tablet left so she believed it was better to get the dose both days once instead of morning and night. Ms. Pannill stated Resident A was administered Keppra on January 28, 2024 at 8 AM but missed the PM dosage and did not receive any Keppra on January 29, 2024. Ms. Keppra stated Resident A had a seizure on January 30, 2024 and he was taken to the hospital. Ms. Pannill stated she emailed Gull Pointe Pharmacy in the morning on January 29, 2024 and by the time Resident A returned from the hospital on January 30, 2024 the medication had been delivered.

Ms. Pannill stated the medication counts are always done on Monday mornings and Mr. Lynch will send an email regarding what medications they need to order. Ms. Pannill stated she met with Mr. Lynch with Recipient Rights and Ms. Goldammer and he informed them he was busy that week and did not look at his computer. Ms. Pannill stated she does not know if there is a policy regarding a second person following up on the emails and she did not remind him to get the prescription because he is normally on top of these issues. Ms. Pannill stated she was also off work the week prior to this occurring and came back to work on January 15, 2024. Ms. Pannill stated Resident A had a seizure last year and this was his second seizure. Ms. Pannill stated Resident A has been out of this medication before on an unknown date and he did not have a seizure then so she does not know if there is a direct correlation between him not receiving the medications and having the seizure.

Special Investigation Report # 2022A0790040 dated October 3, 2022 cited Rule 400.14312 (2) because a former direct care staff member did not order medications on time which resulted in a resident not receiving his Risperidone, Olanzapine, and Trazodone on September 19, 2022. Licensee designee Ms. Goldammer submitted a Corrective Action Plan dated October 10, 2022 with the plan of switching pharmacies, emailing resident medication orders to the pharmacy, and in order to ensure medications do not run out, the Beacon Specialized Living direct care staff member who placed the order will communicate with a phone call when no response is received from the pharmacy.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the interviews with Mr. Lynch, Ms. Himebaugh, Ms. Pannill, and licensee designee Roxanne Goldammer there is evidence Resident A was not administered his Keppra medication which he takes to prevent seizures 5 times between January 27-January 30, 2024 and Resident A had a seizure on January 30, 2024 resulting in Resident A to be transported to the emergency room to receive his Keppra medication. Mr. Lynch sent a request to Gull Pointe Pharmacy on January 15, 2024 for the medication but did not see the response requesting a new prescription and as a result, the medications were not delivered causing Resident A to miss dosages on three days before having a seizure on January 30, 2024.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SIR # 2022A0790040 DATED OCTOBER 3, 2022. CAP COMPLETED.]**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the current license status.

Jennifer Browning _____02/22/2024_____

Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 02/22/2024

_____

Dawn N. Timm Date
Area Manager